Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

LOCAL OFFICE	TELEPHONE NUMBER
CASE NUMBER	DATE

STATEMENT OF COLLATERAL INFORMATION

SECTION 1

RE: _____

The Department of Social and Health Services is in the process of determining the above named person's eligibility. I would appreciate your providing the information requested in Section 2 of this form.

_____
FINANCIAL SERVICE SPECIALIST

SECTION 2

I authorize _____ whose relationship to me
PERSON OR AGENCY

is _____ to provide the following information to the
PHYSICIAN, NEIGHBOR, RELATIVE, ETC.

Department of Social and Health Services.

_____ _____
APPLICANT/RECIPIENT SIGNATURE DATE

SECTION 3

TO THE PERSON PROVIDING THE INFORMATION

Give only information you personally know is true. Write UNKNOWN to information you can not give. Sign and date the form, give your address and phone number. If you need more space, attach pages.

_____ _____
SIGNATURE DATE

_____ _____
ADDRESS PHONE NUMBER